MINUTES OF THE
BOARD OF COMMUNITY HEALTH MEETING
October 11, 2007

Members Present	**Members Absent**
Richard Holmes, Chairman	Dr. Ann McKee Parker
Ross Mason, Vice Chairman (via phone)	
Mark Oshnock, Secretary	
Dr. Inman "Buddy" English	
Kim Gay	
Frank Jones	
Richard Robinson	

The Board of Community Health held its regularly scheduled monthly meeting in the Floyd Room, 20th Floor, West Tower, Twin Towers Building, 200 Piedmont Avenue, Atlanta, Georgia. Commissioner Rhonda Medows was present. (An Agenda and a list of Attendees are attached hereto and made official parts of these Minutes as Attachments #1 and #2).

Approval of Minutes

Chairman Holmes called the meeting to order at 10:43 a.m. The Minutes of the September 13 Meeting were UNANIMOUSLY APPROVED AND ADOPTED.

Commissioner's Comments

Dr. Medows introduced Clyde Reese, the new Executive Director of the Health Planning Division and announced that Dr. Carladenise Edwards will be joining the Department as the Chief of Staff beginning November 15. Dr. Medows said the State Health Benefit Plan presentation will be rescheduled to the November meeting due to the length of the presentations and anticipated discussions on the Certificate of Need Rules and the Disproportionate Share Hospital Payment methodology and allotment plan. Finally, Dr. Medows said she has no new news on the State Children's Insurance Program (SCHIP).

Department Updates

Carie Summers, Chief Financial Officer, presented three items for the Board's review; final adoption of State Health Benefit Plan Rules 111-4-1-.01 and 111-4-1-.13, relating to Other Post Employment Benefit (OPEB) liabilities, a public notice for a rate change in the Mental Retardation Waiver Program, and the Disproportionate Share Hospital program.

Ms. Summers said Rule 111-4-1-.01, adds definitions that are pertinent to new section 111-4-1-.13. Section 111-4-1-.13, sets forth the functions of the Board and Commissioner and how the Department will handle the segregation of Other Post Employment benefit accounting and some reporting requirements, as well as how the Fund will actually be funded. The Department received no written public comments, nor did anyone testify at the public hearing on these rules. Ms. Summers asked members of the Board for favorable consideration for the final adoption of the rules. Ms. Gay MADE a MOTION to approve State Health Benefit Plan Rules 111-4-1-.01 and 111-4-1-.13. Mr. Robinson SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (A copy of the SHBP Rules 111-4-1-.01 and 111-4-1-.13 are hereto attached and made an official part of these Minutes as Attachment # 3).

Next Ms. Summers presented the Mental Retardation Waiver Program Community Habilitation and Support Services Public Notice for initial adoption. The rate increase is specific to support coordination services, often referred to as case management services. The Board previously approved a rate increase for support coordination in April 2007. In 2007, based on appropriations that were made available by the General Assembly, the rate increase was 9.5 %, from $125 Per Member Per Month (PMPM) to $136.88 PMPM. DCH, in conjunction with the Department of Human Resources who administers this waiver, is asking for an additional rate increase effective January 1, 2008. The increase is supported by appropriations made available by the General Assembly in the FY 2008 budget. It is a 9.5 % rate increase and will increase the PMPM from $136.88 to $149.88. Ms. Gay MADE a MOTION to approve for initial adoption the Mental Retardation Waiver Program and Community Habilitation and Support Services Public Notice to be published for public comment. Mr. Robinson SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION WAS UNANIMOUSLY APPROVED. (A copy of the Mental Retardation Waiver Program and Community Habilitation and Support Services Public Notice is attached hereto and made an official part of these Minutes as Attachment # 4).

Ms. Summers continued with a presentation on the Disproportionate Share Hospital (DSH) Program. The DSH program provides additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons. The payments that DCH makes to qualified hospitals are known as DSH payments. The current criteria for DSH eligibility are hospitals have to meet both federal criteria and one of nine state criteria. Allocations are split into two pools—hospitals considered small rural and everyone else. Also there is a premium for being a "deemed facility;" a federal term, which means facilities have to exceed certain thresholds for low income and Medicaid utilization. Within pools, allocations are based on a hospital's share of the total DSH limit. In FY 2007 the total pool was $408.5 million; 15% or $62.4 million went to small rural hospitals, $346.1 million went to all other hospitals. Ms. Summers said

the continued challenges of the DSH Program are no growth in federal funds available to the state and uncompensated costs are historically greater than available funding.

The goals of DSH reform in FY 2008 are to consider making changes that direct DSH funds to hospitals most impacted by uncompensated Medicaid and uninsured costs, and recognize that hospitals rely on DSH as a Medicaid subsidy, even if they are not the most disproportionate. The Department used the advice of the Hospital Advisory Committee which is made of 13 representatives representing hospitals across the state. The Hospital Advisory Committee appointed a subcommittee to study DSH and provided them guiding principles. The Subcommittee held six meetings from August through October 2007. Ultimately, the Subcommittee did not develop a final model to give to the Hospital Advisory Committee. The Guiding Principles are:

- DSH payments must be based upon available, transparent and easily verifiable data. The Subcommittee's recommendation: use 2005 Medicaid data.
- Eligibility criteria should be reconsidered. The subcommittee's recommendation: eliminate all state criteria and use only federal criteria; previously ineligible hospitals considered disproportional now eligible for DSH payment.
- DSH payments should be directed in proportion to uncompensated care provided. The Subcommittee's recommendation:
  - measure of disproportionality – DSH limit as a percentage of total cost;
  - scalability – the more disproportionate receive a larger percentage of their cost from the DSH program.
- DSH payments should be based on uncompensated care. The subcommittee's recommendation:
  ▪use of DSH limit in scalability
  ▪recognition of IGTs used for UPL payments
  ▪hold harmless for hospitals receiving rate adjustments for medical education and neonatal care
  ▪counties the payers of last resort (local subsidies are not included).
- All hospitals should be reimbursed based upon a uniform methodology. The subcommittee's recommendation:
  ▪application of scalability and measurement of disproportionality the same ▪different pools for Grady and small rural hospitals
- The state should maximize DSH and UPL payments. The subcommittee had no new recommendations.
- Changes in DSH payments should not put an undue burden on any hospital group. The subcommittee's recommendations:
  ▪use separate pools to help protect small rural hospitals and Grady; ▪consideration of transition from FY 2007 to new methodology over time
  ▪floors and ceilings on amount of DSH limit that can be covered for any one hospital.
  Ms. Summers said the subcommittee struggled most with this principle and could not come to an agreement on how to consider these recommendations and come up with a methodology that everyone could vote on.

The subcommittee came back to the Hospital Advisory Committee and presented the challenges that kept them from coming to a consensus:

- Recognizing disproportionality
  ▪Should the model recognize disproportionality based on a percentage of uncompensated Medicaid and Uninsured to total cost? DCH Recommendation – adjust DSH limit as a percent of total cost used for allocation of available DSH funds.
  ▪Is it acceptable if less disproportionate hospitals receive less payment if those funds go to more disproportionate hospitals? DCH Recommendation – winners and losers exist within each pool due to shift
- How to transition from old to new
  ▪Should the FY 2008 allocation be based on a blend of the new model and FY 2007 payment amounts? DCH Comments: for rural facilities – assumed they will need more time to adjust to the new methodology give their prior DSH payment level and ability to make up DSH losses with other revenue sources; for non-small rural facilities – 50/50 blend needed in the non-small rural pool to better recognize Grady disproportionality in FY 2008.
  ▪Should the gains or losses (as a percentage) between FY 2007 and FY 2008 by any one group be comparable? DCH comments: deemed facilities take bigger losses due to 10% premium applied last year.
  ▪Is it acceptable to use separate pools as a way to mitigate substantial losses or gains for any one group of hospitals? DCH Recommendation: Maintained separate small rural pool; created a pool for Grady.
- Floors and ceilings for payment amounts
  ▪Should there be a limit on the percentage of the DSH limit that any one hospital can receive? DCH Recommendation: 75% for Grady; 90% for everyone else. DCH Comments: a DSH cap lower than 80 % would have resulted in ALL small rural hospitals taking a loss as compared to last year.
  ▪Should there be a minimum level of disproportionality to receive a DSH payment? DCH Recommendation: no floor.
- Holding harmless any one group of hospital
  ▪Should any one group of hospitals be held harmless from any change to the allocation methodology? DCH Recommendation: small rural DSH pool reduced to 90% last year.
- How to treat new eligibles
  ▪Should newly eligible facilities receive some level of DSH payment in FY 2008? The DCH recommendation: newly eligible limited to 10% of their allocation; however, with a blend of FY

07 and FY 08 at 50/50; new, non-small rural hospitals get 5% of their allocation or $1.9 million; small rural hospitals get $41,000.

Ms. Summers gave a summary by facility type, number of providers under 2007 eligibility criteria, 2007 Net DSH Payments and calculated 2008 Net DSH Payment. She said the model is subject to change pending final data audit and QA on the model. Next steps are submitting a public notice to publish for public comment on October 11, continue data verification for newly eligibles now through November, public comment and board vote on November 8. If the Board approves, the model will be submitted to the Centers for Medicare and Medicaid Services (CMS); notice of interim payments to providers by late November (lesser of 50% of FY 2007 DSH payment or FY 2008 proposed DSH payment); and final payment of balance upon CMS approval for public facilities and upon state fund appropriations made available for private facilities. (A copy of the FY 2008 Disproportionate Share Hospital Program presentation is attached hereto and made an official part of these Minutes as Attachment # 5).

Ms. Summers moved on to the DSH Payments Public Notice. Mr. Oshnock asked if this was a one-year plan or a multiple-year plan. Ms. Summers said this was step one of a multiple-year plan. Mr. Oshnock asked if the Department should develop a multiple year plan now rather than wait. Ms. Summers said there is an issue in FY 2009 that this is the final year of the DSH program in its current form. Federal regulations were issued in January for public comments and the federal government made them final in May. Congress immediately took action and placed a moratorium on them for a year. The new rules inhibit the Department from receiving Intergovernmental Transfers (IGTs) from providers DCH now considers public because the definition of who is public and what is a legitimate IGT will change under these new federal rules. She said in FY 2009 some financing could change some factors that the Department is using in the model. The guiding principles and the policy decisions that were made still apply. She briefly reviewed the public notice bringing to the board's attention eligibility (federal criteria), allocation methodology (scalability) highlighting the separate allocation pools for small-rural hospitals, Grady Memorial Hospital, and all other hospitals, and limits to payments. Secretary Oshnock MADE a MOTION to publish for public comment the Disproportionate Share Hospital Payments Public Notice. Ms. Gay SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (A copy of the Disproportionate Share Hospital Payments Public Notice is hereto attached and made an official part of these Minutes as Attachment # 6).

Chairman Holmes called for a five-minute break. After the break he asked Clyde Reese, Director, Health Planning Division, to review five proposed changes to the Certificate of Need Rules.

Mr. Reese began with Rule 111-2-2-.11(5) Specific Review Considerations for Replacement Facilities or Services. The Department is proposing is to add a clause to Section 5 (c) which will allow nursing facilities to replace themselves within the same county. Currently the rule restricts them to replacement within three miles of their current defined location. Mr. Reese said part of the rationale is that nursing facilities patient population is long-term and stable, and a move within the same county does not raise the same market share and competition issues that other facilities may illicit when they move. However, the facility will be required to apply for a certificate of need. Currently, the Department analyzes twice a year in a batching cycle whether there is a need for new nursing home beds. If a facility is seeking to replace itself, it will not be subject to the batching cycle and may apply at anytime during the year. Secretary Oshnock MADE a MOTION to publish for public comment CON Rule 111-2-2-.11(5). Ms. Gay SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (A copy of CON Rule 111-2-2-.11(5) is hereto attached and made an official part of these Minutes as Attachment # 7).

Rule 111-2-2-.41 is a new set of Specific Review Considerations for Positron Emission Tomography (PET) Units that went through the Health Strategies Council (HSC) Technical Advisory Committee (TAC) process. The rule would clarify that a CON applicant for a mobile unit would be the host facility and not the mobile provider. It also updates the consideration for PET units with regard to state of the art technology that exists now and clarifies that if a facility applies for PET services, they must apply for dual modality PET units. Mr. Reese brought to the Board's attention Section 3 Subsection 3(b). He said the Department has added an exception to the need methodology for fixed or mobile PET units an applicant hospital that treats as inpatients persons who have been diagnosed with cancer and are undergoing treatment for the disease. This is to promote continuity of care. This was not a provision that was voted on and accepted by the TAC. He reminded the Board that the 2007 General Assembly passed HB 429 that changed the role of the Health Strategies Council. Previously the HSC had the authority to approve and send proposals for the rulemaking process to the Board of Community Health. This legislation changed that role to advisory such that if the Department feels there are provisions in whole or part that it would like to put forth, that it would not necessarily vet it through the TAC or HSC process or as with this rule, may be slightly different from the TAC recommendation. This is the only point of divergence that exists; the rest of the proposal is as was reviewed and studied by that TAC. Secretary Oshnock asked if this exception widened the need standards quite a bit; Mr. Reese answered yes. Secretary Oshnock MADE a MOTION to publish for public comment Rule 111-2-2-.41. Mr. Jones SECONDED the MOTION. The MOTION was UNANIMOUSLY APPROVED. (A copy of Rule 111-2-2-.41 is hereto attached and made an official part of these Minutes as Attachment # 8).

Rule 111-2-2-.42 Specific Review Considerations for MegaVoltage Radiation Therapy Services/Units, is an entire body of service specific rules. A TAC was convened, and it was decided that within this body of service specific rules, the new rule would address both conventional radiation therapy and stereotactic radiosurgery known as the MegaVoltage Radiation Therapy (MRT) rule. The rules provide methodology for basic non-special linear accelerators services and a separate methodology for stereotactic radiosurgery services or the special MRT. One point of divergence between the HSC and the TAC version of these rules and what the Department is recommending is Subsection (b) exceptions to the need standard that are contained in the component for non-special MRT services. The Department is putting forth a version that advocates that the exception from the

need standard for existing providers who can show a high utilization in the past two years or 90% utilization that that exception be deleted. The rationale is the CON Commission looked at the issue of exempting from need standards in various CON provisions those existing providers who have high utilization. There is some concern about what that did to the competitive nature of services in a particular area. With that in mind, this is a divergence from the Council and the Committee. The Department is recommending that that exception be deleted. The other provisions are as vetted by that process. Secretary Oshnock MADE a MOTION to publish for public comment Rule 111-2-2-.42. Ms. Gay SECONDED the MOTION. The MOTION was UNANIMOUSLY APPROVED. (A copy of Rule 111-2-2-.42 is hereto attached and made an official part of these Minutes as Attachment # 9).

Rule 111-2-2-.24 deals with Specific Review Considerations for Perinatal Services. The Department is proposing to change the need methodology for aggregate occupancy standards and adverse impact standards which defines how a new or expanded Level 1 Basic Perinatal Services be deleted. Subsection (3)(a) is a prelude to the need methodology for the services outlining that the applicant for new or expanded Level I Basic Perinatal Service will be asked to show sufficient documentation of need for the service without going through a numerical need methodology. A numeric need methodology and aggregate occupancy standard, and adverse impact standards still will be applicable to Level II Intermediate Services and Level III Intensive Care Obstetric Services only. Rationale for this proposed change is Recommendation 7 of the CON Commission. It was not a unanimous vote on this issue, but there was majority support to relax the regulation for Basic Level 1 OB services in this matter. Secretary Oshnock MADE a MOTION to publish for public comment Rule 111-2-2-.24. Dr. English SECONDED the MOTION. The MOTION was UNANIMOUSLY APPROVED. (A copy of Rule 111-2-2-.24 is hereto attached and made an official part of these Minutes as Attachment # 10).

The final rule, Rule 111-2-2-.40, is Specific Review Considerations for Ambulatory Surgery Services. The proposed change amends the definition of multi-specialty ambulatory surgery service. The goal is to include general surgery as a single specialty and to strike the language within this definition that explicitly defines it a multi-specialty service. The effect of this proposed change will allow general surgeons as a group to be eligible for the statutory exemption for physician-owned single specialty office based ambulatory surgery centers. Currently single specialty facilities that are developed by a sole practitioner or a single group practice of private physicians who are of a single specialty can meet various specialty ownership and capital cost criteria, are eligible for a Letter of Nonreviewablility that precludes them from having to go through the CON process for ambulatory surgery centers. Once they receive that designation, they can seek to have that ambulatory surgery center licensed and they are allowed to bill a facility fee to Medicare as a licensed ASC. The proposed change will put general surgery in the same category for purposes of the statutory exemption as specialties of ophthalmology, urology, orthopedics, etc. The rationale is this was a recommendation of the CON Commission, the HSC also voted to recognize general surgery as a single specialty. In addition, some of the medical community, the American Board of Medical Specialties, and the American Board of Surgery, also recognized general surgery in this manner. Vice Chairman Mason MADE a MOTION to publish for public comment Rule 111-2-2-.40. Dr. English SECONDED the MOTION. The MOTION was UNANIMOUSLY APPROVED. (A copy of Rule 111-2-2-.40 is hereto attached and made an official part of these Minutes as Attachment # 11).

Closing Comments

Chairman Holmes said the State Health Benefit Plan presentation will be delayed to next month's meeting. A public hearing will be held on the first wave of CON rules on October 29 and another hearing will be held on November 28 on the rules that were approved today for public comment. He asked board members to attend these public hearings if possible.

Adjournment

There being no further business to be brought before the Board, Mr. Holmes adjourned the meeting at 12:40 pm.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS THE _____ DAY OF

_____, 2007.

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RICHARD L. HOLMES
Chairman

ATTEST TO:

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MARK D. OSHNOCK
Secretary

Official Attachments:

#1 List of Attendees
#2 Agenda
#3 SHBP Rules 111-4-1-.01 and 111-4-1-.13
#4 MRWP/CHSS Public Notice
#5 FY 2008 DSH Program presentation
#6 DSH Payments Public Notice
#7 CON Rule 111-2-2-.11(5)
#8 CON Rule 111-2-2-.41
#9 CON Rule 111-2-2-.42
#10 CON Rule 111-2-2-.24
#11 CON Rule 111-2-2-.40